

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011151	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 06/11/2014
NAME OF PROVIDER OR SUPPLIER STRATFORD RETIREMENT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00147279 completed on May 15, 2014.</p> <p>Complaint IN00147279 Corrected.</p> <p>Survey Date: June 11, 2014</p> <p>Facility number: 011151 Provider number: 155794 AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF:11 Residential: 22 Total: 33</p> <p>Census payor type: Medicare: 7 Other: 26 Total: 33</p> <p>Sample: 4</p> <p>Stratford Retirement LLC was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the investigation of Complaint Number IN00147279.</p> <p>Quality Review was completed by Tammy Alley RN on June 16, 2014.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE